CHAPTER OVERVIEW

This chapter will discuss the indicators that an infant or child may experience if he/she is suffering from failure to thrive.

CURRENT DEFINITIONS

Failure to thrive is a non-diagnostic term for an infant or child who fails to gain in weight and/or length and/or head size and/or development.

Non-organic failure to thrive is a specified medical diagnostic term for an infant or child who has a documented lag of two standard deviations in weight, as well as one standard deviation in one of the following parameters: height, head size and/or development. The lag must be related to environmental disruption and must improve when the disruption is eliminated. By definition, there must be an absence of organic disorders to explain these deviations.

Criteria for non-organic failure to thrive include:

- Normal birth weight, then
- The child falls below the third percentile in weight, or
- The child falls below two standard deviations from previous normal weight.

Failure to thrive may be classified as organic, non-organic, or mixed organic and non-organic. A diagnosis of mixed failure to thrive would apply in cases where the child had a disease with secondary organic psychological reaction. Other terms used synonymously for non-organic failure to thrive include:

- Maltreatment syndrome
- Failure to thrive
- Rumination syndrome
- Growth retardation with maternal deprivation
- Functional hypopituitarism
- Deprivational dwarfism, psychosociogenic dwarfism
- Emotional deprivation
- Environmental deprivation

Non-organic failure to thrive is an interactional disorder in which parental expectations, parental skills, and the resulting home environment are intertwined with the child's developmental capabilities. In some instances it is related to child abuse or neglect. It can be characterized by physical and developmental retardation associated with a disturbed parent-child relationship. These children are slow to develop and learn, are physically small, and have flattened emotional responses, even to pain.

FAMILY DYNAMICS FREQUENTLY ASSOCIATED WITH FAILURE TO THRIVE

- Marital discord
- Serious illness in the family
- Alcoholism
- Childhood deprivation in parent(s)
- Child abuse or neglect
- High-risk pregnancy and delivery
- Inexperience in parenting or caregiving
- Inadequate income
- Job instability
- Chronic unemployment
- Unplanned or unwanted pregnancy
- Illegitimacy
- Disruptive family move late in pregnancy
- Frequent pregnancies at short intervals
- Too many children
- Child of unwanted gender
- Child's appearance distasteful to caregiver
- Caregiver inadequately parented as a child
- Poor self-esteem in caregiver

- Limited perception of other's needs by caregiver
- Depression
- Lack of social supports

INDICATORS IN THE CHILD

- Physical appearance:
  - Emaciated;
  - Wasted appearance;
  - Head appears abnormally large;
  - Muscle wasting.
- Physical symptoms:
  - Infection;
  - Vomiting;
  - Diarrhea.
- Developmental deficiencies:
  - Weight and height below third percentile;
  - Delayed motor development.
- Behavior:
  - Shows little interest in eating;
  - Avoids eye contact;
  - Makes few sounds;
  - Is aloof and unresponsive to nurturing;
  - Stares into space;
  - Rocks back and forth;

- Bangs head;
- Looks at hands/waves hands;
- Is more interested in objects than people.

- Poor hygiene:
  - "Cradle cap" on head;
  - Thinning of hair resulting from laying too long in one position;
  - Irritated skin in diaper area.

SLEEP DISORDERS IN NON-ORGANIC FAILURE TO THRIVE

Studies of failure to thrive children show they suffer from sleep deficiencies. They are often up at night, searching for food and water or roaming around the house. Some studies suggest poor sleep may be one of the factors causing growth retardation. The children may forage for food with constant vigilance required for self-preservation. Researchers believe the tactics used by the child to avoid abuse positively reinforces poor sleep. The children may feel they have to be constantly aware of their surroundings to be safe. In sleep, they cannot be safe. When the children are removed from the existing home environment, their poor sleep habits disappear.

PHYSICAL FINDINGS

Children with non-organic failure to thrive have failure to gain or maintain weight in first 12 months (50% in first six months). They show an inadequate weight gain starting at birth. After the first year, their primary deficit is in the long bone growth. Also present is vasomotor instability, manifested by blue and cold hand and feet, small ulcers, and early gangrene.

EVALUATION COMPONENTS

In evaluating a child for failure to thrive, the following components should be considered:

- The child's history, focusing on social, nutritional, developmental, and the prenatal care received;
- Physical examination, including complete heights and weights and neurological/psychological exam;
- Medical tests to rule out organic etiology. Organic causes of failure to thrive include:

- Unusual syndromes, chromosomal abnormalities, and skeletal disorders;
- Intrauterine growth retardation;
- Central nervous system disorder as in a brain-damaged infant;
- Familial short stature, slow maturation, or primordial dwarfism;
- Chronic infection;
- Chronic renal (kidney) failure;
- Congenital heart disease;
- Chronic pulmonary disease;
- Chronic hepatic (liver) disease; and
- Chronic gastrointestinal disease.

- Feeding trial (10 – 14 days) in the hospital:
  - Daily calorie counts;
  - Nursing observations of child's behavior.
- Observation of caregiver's interaction with the child:
  - Eye contact;
  - Physical contact;
  - Verbal communication;
  - Feeding behavior;
  - Bathing, diapering, dressing;
  - Playing;
  - Caregiver's response to child's crying.
- Observation of child's response to strangers.

INTERVENTION

- Test malnutrition, dehydration and other health problems immediately;

- Focus on finding relief for the child as well as the caregiver:
    - Support positive caregiving skills; provide positive feedback to the caregiver on the child's care; assume a non-accusatory posture;
    - Attempt to diminish high expectations placed on the child;
    - A "rest cure" may be needed – temporary foster care, or a low expectation environment.
- Conduct team evaluation of the child's development. Consult physician, nurse, mental health professional, and nutritionist.
- Continue with long-term follow-up.

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Sources: This chapter was adapted, with permission, from: Center for Advance Studies on Human Services, *Michigan Self Instructional Orientation to Children's Protective Services,* Office of Children and Youth Services, Michigan Department of Social Services. 1981.

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MEMORANDA HISTORY: